ZUBKOV
DENTAL

PATIENT INFORMATION

Patient Name : _____
Last First MI
Preferred Name _____ Birthday _____ M _____ F _____

S.S. # _____ Driver's License # _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____)_____ Business Phone (_____)_____

Cell Phone (_____)_____ E-Mail _____

Employer _____ Occupation_____
Can we contact you at work? _____Yes _____ No

When & Where Are Best Times To Reach You? _____

Whom May We Thank For Referring You To Our Practice? _____

Whom May We Contact In The Event of An Emergency? Name: _____

Relationship _____ Phone No. _____

INSURNACE INFORMATION

Name of Insured _____ Is insured a patient? _____ Yes _____ No

Insured's Birthdate _____ ID# _____ Group # _____

Insured's Home Address _____
Street State Zip
Insured's Employer Name _____

Patient's relationship to insured: _____ Self _____ Spouse _____ Child _____ Other

Insurance Plan Name _____ Telephone # _____

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COSMETIC INFORMATION

Are you pleased with the appearance of your teeth when you smile? . . . . .Yes ____ No____
Do you have stains on your teeth that won't brush off? . . . . Yes ____ No____
Are your teeth as white as you'd like them to be? . . . . . .Yes ____ No____
Do you get canker sores? . . . . . Yes ____ No____
Do you have any concerns about bad breath odor? . . . . Yes ____ No____

Do you have old black fillings or a crown with dark margins around them you'd like replaced with the newer tooth color Restorations? ……. . . . . ..…. … Yes ____ No____
If you could change anything about the appearance of your smile, what would that be?
_____
_____

MEDICAL INFORMATION

Name of family physician _____ Phone _____
Date of last physical? _____

Are you under medical treatment now? . . . . . Yes ____ No____
Have you had any major operations? If so, what . . . . Yes ____ No____
Have you ever had a serious accident involving head/mouth injuries? . . . .Yes ____ No____
Do you smoke or use tobacco in any form? . . . . . Yes ____ No____
Are you on a diet at this time? . . . . . Yes ____ No____
Are you in general good health at this time? . . . . . Yes ____ No____
Have previous cuts healed slowly or presented other complications? . . . . . Yes ____ No____
Are you pregnant? . . . . . Yes ____ No____ Due Date:_____
Do you have a history of fainting? . . . . Yes ____ No____

Is there any other information that should be known about your health or previous dental visits?
Yes ____ No____
If yes, what? _____

DENTAL HISTORY

Reason for todays visit? _____
Former Dentist: _____ Date of last visit:_____Date of last x-rays:_____

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CHECK THE FOLLOWING:

Aids/ HIV	☐ YES ☐ NO	Jaundice	☐ YES ☐ NO
Anemia	☐ YES ☐ NO	Jaw Pain	☐ YES ☐ NO
Arthritis, Rheumatism	☐ YES ☐ NO	Kidney Disease	☐ YES ☐ NO
Artificial Heart Valve	☐ YES ☐ NO	Low Blood Pressure	☐ YES ☐ NO
Artificial Joints	☐ YES ☐ NO	Mitral Valve Prolapse	☐ YES ☐ NO
Asthma	☐ YES ☐ NO	Nervous Problems	☐ YES ☐ NO
Back Problems	☐ YES ☐ NO	Pacemaker	☐ YES ☐ NO
Bleeding abnormally	☐ YES ☐ NO	Psychiatric Care	☐ YES ☐ NO
Blood Disease	☐ YES ☐ NO	Radiation Treatment	☐ YES ☐ NO
Cancer	☐ YES ☐ NO	Respiratory Disease	☐ YES ☐ NO
Chemical Dependency	☐ YES ☐ NO	Rheumatic fever	☐ YES ☐ NO
Chemotherapy	☐ YES ☐ NO	Scarlet Fever	☐ YES ☐ NO
Circulatory Problems	☐ YES ☐ NO	Shortness of Breath	☐ YES ☐ NO
Congenital Heart Lesion	☐ YES ☐ NO	Sinus Trouble	☐ YES ☐ NO
Cortisone Treatments	☐ YES ☐ NO	Skin Rash	☐ YES ☐ NO
Cough	☐ YES ☐ NO	Special Diet	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO	Stroke	☐ YES ☐ NO
Emphysema	☐ YES ☐ NO	Swollen Feet or Ankles	☐ YES ☐ NO
Epilepsy	☐ YES ☐ NO	Swollen Neck Glands	☐ YES ☐ NO
Fainting or dizziness	☐ YES ☐ NO	Thyroid Problems	☐ YES ☐ NO
Glaucoma	☐ YES ☐ NO	Tonsillitis	☐ YES ☐ NO
Headaches	☐ YES ☐ NO	Tuberculosis	☐ YES ☐ NO
Heart Murmur	☐ YES ☐ NO	Tumor of growth in Head or Neck	☐ YES ☐ NO
Heart Problems	☐ YES ☐ NO	Ulcer	☐ YES ☐ NO
Hepatitis Type:	☐ YES ☐ NO	Vaneral Disease	☐ YES ☐ NO
Herpes	☐ YES ☐ NO	Weight loss	☐ YES ☐ NO
High Blood Pressure	☐ YES ☐ NO		

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HEALTH INFORMATION

MEDICATIONS:

List any medications you are currently taking and the correlating diagnosis: _____

_____

_____

Pharmacy Name:_____

ALLERGIES:

_____ Aspirin _____ Penicillin

_____ Codeine _____ Sulfa

_____ Iodine _____ Latex

_____Local Anesthetic _____ OTHER

_____

Women:

Are you Pregnant? ___Yes ___ NO Due Date: _____	Are you Nursing? ___Yes ___ NO
Taking Birth Control Pills? ___Yes ___ NO	

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for the benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date _____

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PATIENT CONSENT and PRIVACY RIGHTS (HIPAA – 4/14/2003)

CONSENT FOR TREATMENT

1. I hereby and voluntarily consent to such procedures, including diagnostic and treatment, as may be deemed necessary by Associates in Dentistry .

2. I further understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to Associates in Dentistry to make any/all changes and additions as necessary

3. I understand that I have the right to question, discuss or refuse any or all tests and/or treatments **before** the work has begun.

4. I understand that dentistry is not an exact science and, therefore, no guarantees or assurances have been made by anyone regarding the dental treatment which I have requested and authorized.

5. I understand that the final opportunity to make changes to dental work such as bridges, crowns, dentures, partials, and night guards (including shape, fit size, and color) will be **before the final cementation or insertion**.

6. I give consent to Associates in Dentistry and his associates to call in prescriptions and to consult with my health care providers.

7. I acknowledge that I have had the opportunity to read this form. My questions have been answered to my satisfaction. **I understand its contents. I can receive a copy of this form upon request.**

CONSENT TO RELEASE MEDICAL/DENTAL INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS

1. I authorize the release of any medical information necessary to process my insurance claims and necessary information for billing statements.
2. I authorize the release of my name to identify work sent to medical and dental laboratories.
3. I authorize and request payment directly to Associates in Dentistry of medical/dental benefits otherwise payable to me. They will not exceed Associates in Dentistry regular charges.
4. I understand that I am financially responsible to Associates in Dentistry for any deductible, co-insurance or non-covered services. I further understand that once the work is initiated, I am financially responsible.
5. I agree this authorization will cover all medical/dental services rendered until such authorization is revoked by me through written notification.
6. I agree that a photocopy of this form may be used in lieu of the original.

PATIENT NAME (PRINT) _____ Date _____

PATIENT/GUARDIAN SIGNATURE _____ Date _____